FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040444

Facility Name: SHERIDAN SHORES CARE

Address: 5838 NORTH SHERIDAN (Number) CHICAGO (City) 60660 (Zip Code)

County: COOK

Telephone Number: (773) 769-2230 **Fax #** (773) 769-3579

IDPA ID Number: 363873049001

Date of Initial License for Current Owners: 06/04/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,564	429	1,318	15,311	8
9	SNF/PED					9
10	ICF	48,013	1,000		49,013	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,577	1,429	1,318	64,324	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.74%

D. How many bed-hold days during this year were paid by Public Aid?
2316 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 953

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,825	23,932	14,083	238,840		238,840	(2,377)	236,463			1
2	Food Purchase		244,971		244,971	(27,850)	217,122	3,098	220,220			2
3	Housekeeping	156,406	40,808		197,214		197,214	2,000	199,214			3
4	Laundry	63,867	20,234		84,101		84,101		84,101			4
5	Heat and Other Utilities			214,112	214,112		214,112	2,650	216,762			5
6	Maintenance	51,532		196,948	248,480		248,480	(11,373)	237,107			6
7	Other (specify):*							2,260	2,260			7
8	**TOTAL General Services**	472,630	329,945	425,143	1,227,718	(27,850)	1,199,869	(3,741)	1,196,127			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,765,816	56,958	64,851	1,887,625		1,887,625	22,443	1,910,068			10
10a	Therapy	89,967	3,995	7,651	101,613		101,613	2,323	103,936			10a
11	Activities	124,803	8,710	3,813	137,326		137,326	612	137,938			11
12	Social Services	125,138	923	3,316	129,377		129,377	624	130,001			12
13	Nurse Aide Training			330	330		330		330			13
14	Program Transportation											14
15	Other (specify):*							5,140	5,140			15
16	**TOTAL Health Care and Programs**	2,105,724	70,586	85,961	2,262,271		2,262,271	31,142	2,293,413			16
	C. General Administration											
17	Administrative	11,989		109,188	121,177		121,177	(4,232)	116,945			17
18	Directors Fees											18
19	Professional Services			287,418	287,418		287,418	(227,067)	60,351			19
20	Dues, Fees, Subscriptions & Promotions			64,973	64,973		64,973	(21,728)	43,245			20
21	Clerical & General Office Expenses	104,001	24,681	334,164	462,846		462,846	(160,492)	302,354			21
22	Employee Benefits & Payroll Taxes			526,121	526,121	27,850	553,971	(16,494)	537,477			22
23	Inservice Training & Education			4,968	4,968		4,968	(685)	4,283			23
24	Travel and Seminar			4,917	4,917		4,917	1,401	6,318			24
25	Other Admin. Staff Transportation			1,263	1,263		1,263	(21)	1,242			25
26	Insurance-Prop.Liab.Malpractice			214,622	214,622		214,622	1,357	215,979			26
27	Other (specify):*							27,750	27,750			27
28	**TOTAL General Administration**	115,990	24,681	1,547,634	1,688,305	27,850	1,716,155	(400,211)	1,315,943			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,694,344	425,212	2,058,738	5,178,294		5,178,294	(372,810)	4,805,484			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHERIDAN SHORES CARE #0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			113,603	113,603		113,603	(14,611)	98,992			30
31	Amortization of Pre-Op. & Org.			2,278	2,278		2,278	9,759	12,037			31
32	Interest			231,441	231,441		231,441	10,833	242,274			32
33	Real Estate Taxes			215,213	215,213		215,213	3,845	219,058			33
34	Rent-Facility & Grounds			1,955,577	1,955,577		1,955,577	(941,942)	1,013,635			34
35	Rent-Equipment & Vehicles			4,653	4,653		4,653	3,983	8,636			35
36	Other (specify):*											36
37	TOTAL Ownership			2,522,765	2,522,765		2,522,765	(928,133)	1,594,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,503	16,661	103,164		103,164	(2,167)	100,997			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		86,503	119,591	206,094		206,094	(2,167)	203,927			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,694,344	511,715	4,701,094	7,907,153		7,907,153	(1,303,110)	6,604,043			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,987)	30		9
10	Interest and Other Investment Income	(29)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(53)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(282,693)	21		24
25	Fund Raising, Advertising and Promotional	(9,922)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(286)	20		28
29	Other-Attach Schedule	(1,047,580)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,365,550)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	62,440		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 62,440		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,303,110)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SHERIDAN SHORES CARE

ID# 0040444

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OUT OF PERIOD C.NA TRAINING	$ (685)	23	1
2	NON ALLOWABLE LEGAL	(52,113)	19	2
3	BANK CHARGES	(2,066)	21	3
4	THEFT LOSS	(35)	21	4
5	MISC INCOME	(17)	21	5
6	IL COUNCIL COPE	(3,445)	20	6
7	RENTAL INCOME	(7,219)	34	7
8	BONUS RENT	(940,000)	34	8
9	MANAGEMENT FEES	(30,000)	19	9
10	ROTHNER MGT FEE	(12,000)	17	10
11				11
12				12
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			5,115	(4,003)		(3,489)						(2,377)	1
2	Food Purchase	(53)		(481)			3,632						3,098	2
3	Housekeeping			2,000									2,000	3
4	Laundry													4
5	Heat and Other Utilities			2,650									2,650	5
6	Maintenance			14,682	(26,056)		1						(11,373)	6
7	Other (specify):*			2,073			187						2,260	7
8	**TOTAL General Services**	(53)		26,039	(30,059)		331						(3,741)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			29,962	(4,233)		34	(3,320)					22,443	10
10a	Therapy			5,973	(3,650)								2,323	10a
11	Activities			2,313	(1,701)								612	11
12	Social Services			2,176	(1,552)								624	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,140									5,140	15
16	**TOTAL Health Care and Programs**			45,564	(11,136)		34	(3,320)					31,142	16
	C. General Administration													
17	Administrative	(12,000)		48,189	(89,013)	48,503	89						(4,232)	17
18	Directors Fees													18
19	Professional Services	(82,113)		7,064	(152,035)		17						(227,067)	19
20	Fees, Subscriptions & Promotions	(13,653)		1,924	(10,007)		8						(21,728)	20
21	Clerical & General Office Expenses	(284,811)		138,203	(14,040)		156						(160,492)	21
22	Employee Benefits & Payroll Taxes				(16,494)								(16,494)	22
23	Inservice Training & Education	(685)											(685)	23
24	Travel and Seminar			1,400			1						1,401	24
25	Other Admin. Staff Transportation			75	(275)		179						(21)	25
26	Insurance-Prop.Liab.Malpractice			1,357									1,357	26
27	Other (specify):*			20,949		6,801							27,750	27
28	**TOTAL General Administration**	(393,262)		219,161	(281,864)	55,304	450						(400,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(393,315)		290,764	(323,059)	55,304	815	(3,320)					(372,810)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,987)		10,376									(14,611)	30
31	Amortization of Pre-Op. & Org.		9,759										9,759	31
32	Interest	(29)		10,859			3						10,833	32
33	Real Estate Taxes			3,845									3,845	33
34	Rent-Facility & Grounds	(947,219)		5,277									(941,942)	34
35	Rent-Equipment & Vehicles			3,974			9						3,983	35
36	Other (specify):*													36
37	TOTAL Ownership	(972,235)	9,759	34,331			12						(928,133)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(97)	(2,070)					(2,167)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(97)	(2,070)					(2,167)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,365,550)	9,759	325,095	(323,059)	55,304	730	(5,390)					(1,303,110)	45

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				EDGEWATER CARE & REHAB BLDG, LLC.		BUILDING CO

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income / Expense	$ 1,015,577	Edgewater Care & Rehabilitation Center Bldg, LLC	100.00%	$ 1,015,577	$	1
2	V	32	Rental Inc. / Exp. - R/E Tax	253,645	Edgewater Care & Rehabilitation Center Bldg, LLC	100.00%	253,645		2
3	V	31	Amortization		Edgewater Care & Rehabilitation Center Bldg, LLC	100.00%	9,759	9,759	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,269,222			$ 1,278,981	$ * 9,759	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 5,115	$ 5,115	15
16	V	2	FOOD		CARE CENTERS, INC.	100.00%	(481)	(481)	16
17	V	3	HOUSEKEEPING		CARE CENTERS, INC.	100.00%	2,000	2,000	17
18	V	5	UTILITIES		CARE CENTERS, INC.	100.00%	2,650	2,650	18
19	V	6	REPAIRS AND MAINT.		CARE CENTERS, INC.	100.00%	14,682	14,682	19
20	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS, INC.	100.00%	2,073	2,073	20
21	V	10	NURSING		CARE CENTERS, INC.	100.00%	29,962	29,962	21
22	V	10A	THERAPY		CARE CENTERS, INC.	100.00%	5,973	5,973	22
23	V	11	ACTIVITIES		CARE CENTERS, INC.	100.00%	2,313	2,313	23
24	V	12	SOCIAL SERVICES		CARE CENTERS, INC.	100.00%	2,176	2,176	24
25	V	15	EMP. BEN. - HEALTHCARE		CARE CENTERS, INC.	100.00%	5,140	5,140	25
26	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	48,189	48,189	26
27	V	19	PROFESSIONAL FEES		CARE CENTERS, INC.	100.00%	7,064	7,064	27
28	V	20	DUES, SUBSCRIPTIONS		CARE CENTERS, INC.	100.00%	1,924	1,924	28
29	V	21	CLERICAL AND GENERAL		CARE CENTERS, INC.	100.00%	138,203	138,203	29
30	V	24	SEMINARS		CARE CENTERS, INC.	100.00%	1,400	1,400	30
31	V	25	AUTO EXPENSE		CARE CENTERS, INC.	100.00%	75	75	31
32	V	26	INSURANCE		CARE CENTERS, INC.	100.00%	1,357	1,357	32
33	V	27	EMP. BEN. - GEN. ADMIN.		CARE CENTERS, INC.	100.00%	20,949	20,949	33
34	V	30	DEPRECIATION		CARE CENTERS, INC.	100.00%	10,376	10,376	34
35	V	32	INTEREST		CARE CENTERS, INC.	100.00%	10,859	10,859	35
36	V	33	REAL ESTATE TAXES		CARE CENTERS, INC.	100.00%	3,845	3,845	36
37	V	34	BUILDING RENT - UNRELATED		CARE CENTERS, INC.	100.00%	5,277	5,277	37
38	V	35	EQUIPMENT RENTAL		CARE CENTERS, INC.	100.00%	3,974	3,974	38
39	Total			$			$ 325,095	$ * 325,095	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 4,003	CARE CENTERS, INC.	100.00%	$	$ (4,003)	15
16	V	19	ACCOUNTING	9,428	CARE CENTERS, INC.	100.00%		(9,428)	16
17	V	19	ANCIL ADMIN FEE	13,160	CARE CENTERS, INC.	100.00%		(13,160)	17
18	V	19	BOOKEEPING	22,372	CARE CENTERS, INC.	100.00%		(22,372)	18
19	V	19	DATA PROCESSING	3,948	CARE CENTERS, INC.	100.00%		(3,948)	19
20	V	19	LEGAL	10,007	CARE CENTERS, INC.	100.00%		(10,007)	20
21	V	19	MANAGEMENT FEE	92,120	CARE CENTERS, INC.	100.00%		(92,120)	21
22	V	19	PROFESSIONAL FEES	1,000	CARE CENTERS, INC.	100.00%		(1,000)	22
23	V	20	ADVERTISING	10,007	CARE CENTERS, INC.	100.00%		(10,007)	23
24	V	25	REBILL BUS	275	CARE CENTERS, INC.	100.00%		(275)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	16,494	CARE CENTERS, INC.	100.00%		(16,494)	26
27	V	1	REBILL. PAYROLL DIETARY		CARE CENTERS, INC.	100.00%			27
28	V	3	REBILL. PAYROLL HSKPNG		CARE CENTERS, INC.	100.00%			28
29	V	6	REBILL. PAYROLL MAINT.	26,056	CARE CENTERS, INC.	100.00%		(26,056)	29
30	V	10	REBILL. PAYROLL NURSING	4,233	CARE CENTERS, INC.	100.00%		(4,233)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	3,650	CARE CENTERS, INC.	100.00%		(3,650)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	1,701	CARE CENTERS, INC.	100.00%		(1,701)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	1,552	CARE CENTERS, INC.	100.00%		(1,552)	33
34	V	17	REBILL. PAYROLL ADMIN.	89,013	CARE CENTERS, INC.	100.00%		(89,013)	34
35	V	21	REBILL. PAYROLL CLERICAL	14,040	CARE CENTERS, INC.	100.00%		(14,040)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 323,059			$	$ * (323,059)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$	$	15
16	V	15	EMP. BEN HEALTHCARE		CARE CENTERS, INC.	100.00%			16
17	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	48,503	48,503	17
18	V	27	EMP. BEN GEN. ADMIN.		CARE CENTERS, INC.	100.00%	6,801	6,801	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 55,304	$ * 55,304	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 2,052	$ 2,052	15
16	V	2	FOOD		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	3,632	3,632	16
17	V	6	MAINTENANCE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	1	1	17
18	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	187	187	18
19	V	10	NURSING		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	34	34	19
20	V	17	ADMINISTRATIVE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	89	89	20
21	V	19	PROFESSIONAL FEES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	17	17	21
22	V	20	DUES, FEES, SUB.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	8	8	22
23	V	21	CLERICAL & GENERAL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	156	156	23
24	V	24	SEMINARS		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	1	1	24
25	V	25	TRAVEL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	179	179	25
26	V	32	INTEREST		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	3	3	26
27	V	35	RENT - EQUIPMENT & VEHICLES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	9	9	27
28	V	39	ANCILLARY ENTERAL SUPPLIES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	119	119	28
29	V	1	DIETARY SUPP	5,541	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(5,541)	29
30	V	39	ANCILLARY SUPP	216	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(216)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,757			$ 6,487	$ * 730	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 27,341	$ 27,341	15
16	V	39	MEDICAL SUPPLIES		XCEL MEDICAL SUPPLLY LLC	100.00%	17,045	17,045	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	30,661	XCEL MEDICAL SUPPLLY LLC	100.00%		(30,661)	19
20	V	39	MEDICAL SUPPLIES	19,115	XCEL MEDICAL SUPPLLY LLC	100.00%		(19,115)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,776			$ 44,386	$ * (5,390)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 99,469	$ 99,469	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	99,469	CCS EMPLOYEE BENEFIT GROUP	100.00%		(99,469)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 99,469			$ 99,469	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	OWNER	Administrative	3.19%	See Attached	2.07	2.88%		$		1
2	NORM GOLDBERG	OWNER	Administrative	2.13%	See Attached	2.11	4.22%	Salary Alloc	4,264	17-7	2
3	MARK STEINBERG	RELATIVE	Administrative	0%	See Attached	2.11	4.22%	Salary Alloc	1,877	17-7	3
4	ZEV GOLDBERG	RELATIVE	Clerical	0%	See Attached	1.09	4.24%	Salary Alloc	706	21-7	4
5	ARIEL GOLDBERG	RELATIVE	Clerical	0%	See Attached	.18	4.12%	Salary Alloc	106	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,953		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	64,324	$ 5,115	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		64,324	(481)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	64,324	2,000	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		64,324	2,650	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	64,324	14,682	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		64,324	2,073	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	64,324	29,962	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	64,324	5,973	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	64,324	2,313	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	64,324	2,176	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		64,324	5,140	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	64,324	48,189	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		64,324	7,064	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		64,324	1,924	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	64,324	138,203	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		64,324	1,400	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		64,324	75	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		64,324	1,357	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		64,324	20,949	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		64,324	10,376	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		64,324	10,859	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		64,324	3,845	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		64,324	5,277	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		64,324	3,974	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 325,095	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		48,503	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			6,801	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 55,304	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	8,244	2,052	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		8,244	3,632	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		8,244	1	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		8,244	187	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		8,244	34	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		8,244	89	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		8,244	17	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		8,244	8	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		8,244	156	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		8,244	1	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		8,244	179	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		8,244	3	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		8,244	9	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		8,244	119	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 6,487	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 44,386	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 44,386	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 99,469	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 99,469	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholders Loan	X		WORKING CAPITAL				585,000			51,716	6
7												7
8	DIAWA		X	LINE OF CREDIT				1,926,023			168,921	8
9	TOTAL Facility Related						$	$ 2,511,023			$ 220,637	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							210,261			21,637	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 210,261			$ 21,637	14
15	TOTALS (line 9+line14)						$	$ 2,721,284			$ 242,274	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	HUNTER MANAGEMENT	X					$	$ 210,261			$ 10,744	1
2	ALLOCATION CCI	X									10,859	2
3	INSURANCE FINANCING		X								63	3
4	INTEREST INCOME										(29)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 210,261			$ 21,637	21

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	299,008	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	245,411	2
3. Under or (over) accrual (line 2 minus line 1).	$	(53,597)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	272,655	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	219,058	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	301,529	8
	1997	285,880	9
	1998	286,694	10
	1999	284,769	11
	2000	241,566	12

2001 ACCRUAL = 2000 TAX 241566.48 * 1.05 * 212/365

ALLOCATION FROM CARE CENTERS = $3845

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERIDAN SHORES CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-402-027-0000	LTC PROPERTY	$ 120,783.24	$ 120,783.24
2.	14-05-402-028-0000	LTC PROPERTY	$ 120,783.24	$ 120,783.24
3.	SEE ATTACHED	HOME OFFICE ALLOCATION	$ 66,986.83	$ 2,830.35
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 308,553.31	$ 244,396.83

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 82,955
2. Number of Years Over Which it is Being Amortized: VARIOUS
3. Current Period Amortization: 12,037
4. Dates Incurred: VARIOUS

Nature of Costs: PREPAID ASSIGNMENT FEES, FINANCING FEES
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ALLOC CCI			$ 2,704	1
2					2
3	TOTALS			$ 2,704	3

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874			2,145	2,145	17,878	9
10	Various			1994	57,552			2,878	2,878	21,811	10
11	Various			1995	146,433			7,322	7,322	48,722	11
12	Various			1996	67,704			3,385	(3,385)	18,938	12
13	Various			1997	53,902			2,696	2,696	12,261	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		60,380	1,595		2,028	433	9,992	68
69	Financial Statement Depreciation			113,603			(113,603)		69
70	TOTAL (lines 4 thru 69)		$ 428,845	$ 115,198		$ 20,454	$ (101,514)	$ 129,602	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 428,845	$ 115,198		$ 20,454	$ (94,744)	$ 129,602	1
2	ELEVATOR RENOV	1998	1,508			75	75	300	2
3	PLUMBING RENOV	1998	844			42	42	165	3
4	BOILER RENOV	1998	2,560			128	128	501	4
5	DOORS	1998	3,200			160	160	613	5
6	DRYWALL	1998	20,000			1,000	1,000	3,833	6
7	HINDGES	1998	2,579			129	129	495	7
8	WALLPAPER	1998	3,673			184	184	705	8
9	PLASTER DRYWALL	1998	15,000			750	750	2,813	9
10	FIRE DAMPERS	1998	9,799			490	490	1,838	10
11	DOOR CLOSURES	1998	3,129			156	156	585	11
12	ELEV RENOV	1998	533			27	27	101	12
13	SECURITY SYS	1998	3,195			160	160	587	13
14	HVAC RENOV	1998	3,794			190	190	697	14
15	FIRE DOORS	1998	1,885			94	94	345	15
16	DRYWALL	1998	8,250			413	413	1,514	16
17	HEAT DAMPERS	1998	7,950			398	398	1,426	17
18	DRYWALL	1998	7,200			360	360	1,290	18
19	FIRE DAMPERS	1998	9,240			462	462	1,656	19
20	FIRE DOOR	1998	2,555			128	128	459	20
21	ELEV.RENOV.	1998	4,364			218	218	781	21
22	DRYWALL	1998	4,150			208	208	728	22
23	SMOKE DETECTION	1998	7,000			350	350	1,225	23
24	ELEVATOR RENOV	1998	776			39	39	137	24
25	DRYWALL	1998	9,500			475	475	1,623	25
26	PLUMBING RENOV	1998	5,530			277	277	946	26
27	HVAC RENOV	1998	642			32	32	109	27
28	METAL DOOR	1998	1,656			83	83	284	28
29	DRYWALL	1998	4,000			200	200	667	29
30	PLUMBING RENOV	1998	2,679			134	134	447	30
31	LIFE SAFETY CODE	1998	6,000			300	300	975	31
32	WALLPAPER	1998	941			47	47	149	32
33	WALLPAPER	1998	6,000			300	300	1,125	33
34	TOTAL (lines 1 thru 33)		$ 588,977	$ 115,198		$ 28,463	$ (86,735)	$ 158,721	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 588,977	$ 115,198		$ 28,463	$ (86,735)	$ 158,721	1
2	DRYWALL	1998	3,800			190	190	586	2
3	GENERATOR	1998	1,158			58	58	179	3
4	BOILER TUBES	1998	6,713			336	336	1,036	4
5	TRANSMITTER	1998	876			44	44	136	5
6	LIFE SAFETY	1999	4,500			225	225	675	6
7	PHONE RENOV	1999	861			43	43	125	7
8	HEATER RENOV	1999	1,080			54	54	158	8
9	MIXER RENOV	1999	824			41	41	120	9
10	SMOKE DAMPER	1999	789			39	39	114	10
11	OXYGEN EXHAUST	1999	5,677			284	284	828	11
12	SPRINKLER SYSTEM	1999	3,240			162	162	473	12
13	DOOR/HINGES	1999	1,445			72	72	204	13
14	CARPET	1999	589			29	29	82	14
15	PAINT	1999	592			30	30	85	15
16	CUBICLE CURTAINS	1999	845			42	42	116	16
17	HEATER RENOV	1999	1,903			95	95	253	17
18	COMPRESSOR	1999	1,209			60	60	160	18
19	GENERATOR RENOV	1999	535			27	27	63	19
20	ELEVATOR RENOV	1999	3,301			165	165	371	20
21	TV WIRING	1999	6,500			325	325	704	21
22	PAVEMENT IMPROV	1999	1,990			100	100	250	22
23	PAVEMENT IMPROV	1999	3,980			199	199	498	23
24	TUCKPOINTING	1999	2,200			110	110	275	24
25	A/C RENOV	1999	573			29	29	73	25
26	CEILING TILE	1999	703			35	35	85	26
27	CEILING TILE	1999	703			35	35	85	27
28	COVE BASE	1999	2,156			108	108	279	28
29	LANDSCAPING	1999	1,000			50	50	129	29
30	BOILER RENOV	1999	741			37	37	96	30
31	KEYSWITCH	1999	865			43	43	111	31
32	CEILING TILE	1999	536			27	27	63	32
33	DOORS	1999	2,895			145	145	338	33
34	TOTAL (lines 1 thru 33)		$ 653,756	$ 115,198		$ 31,702	$ (83,496)	$ 167,471	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 653,756	$ 115,198		$ 31,702	$ (83,496)	$ 167,471	1
2	GENERATOR RENOV	1999	964			48	48	112	2
3	GENERATOR RENOV	1999	1,176			59	59	138	3
4	WOOD DOORS	1999	2,350			118	118	285	4
5	WIRING	1999	945			47	47	114	5
6	GENERATOR RENOV	1999	545			27	27	54	6
7	TRANSMITTER	1999	732			37	37	74	7
8	BOILER RENOV	1999	702			35	35	76	8
9	TILE	1999	542			27	27	70	9
10	A/C RENOV	1999	1,351			68	68	176	10
11	REFRIG RENOV	1999	1,143			57	57	114	11
12	PAINT	2000	3,760			188	188	376	12
13	TV WIRING	2000	7,384			369	369	738	13
14	PAINT	2000	2,956			148	148	271	14
15	CORNERS GUARDS	2000	2,933			147	147	270	15
16	FYRE-SHIELD	2000	987			49	49	90	16
17	WALLPAPER	2000	22,360			1,118	1,118	1,957	17
18	CORNER GUARDS	2000	3,618			181	181	317	18
19	PAINT	2000	759			38	38	63	19
20	PAINT	2000	(111)			6	6	10	20
21	PAINT	2000	621			31	31	52	21
22	PAINT	2000	301			15	15	25	22
23	ELECTRICAL	2000	2,170			109	109	182	23
24	SECO REFRIGERATION	2000	1,572			79	79	125	24
25	PAINT	2000	700			35	35	55	25
26	WIRING	2000	1,225			61	61	92	26
27	LIFT HANDLES	2000	1,503			75	75	113	27
28	RADIATOR	2000	8,963			448	448	672	28
29	WIRING	2000	725			36	36	51	29
30	WIRING	2000	500			25	25	35	30
31	AWNING	2000	6,970			349	349	494	31
32	CAMERA SYSTEM	2000	2,274			114	114	152	32
33	HVAC	2000	525			53	53	66	33
34	TOTAL (lines 1 thru 33)		$ 736,901	$ 115,198		$ 35,899	$ (79,299)	$ 174,890	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 736,901	$ 115,198		$ 35,899	$ (79,299)	$ 174,890	1
2	RADIATOR	2000	11,823			591	591	690	2
3	REFRIG RENOV	2000	2,254			113	113	217	3
4	REFRIG RENOV	2000	4,180			209	209	383	4
5	COVE BASE	2000	3,200			160	160	280	5
6	HANDRAILS	2000	3,911			196	196	327	6
7	COVE BASE	2000	854			43	43	72	7
8	PAINT	2000	1,954			98	98	147	8
9	PAINT	2000	969			48	48	68	9
10	WALL GUARD	2000	1,840			92	92	130	10
11	DRYWALL	2000	1,200			60	60	80	11
12	DOOR HOLDERS	2000	19,985			999	999	1,249	12
13	WINDOW TREATMENTS	2000	5,587			279	279	349	13
14	BLOWER WHEELS	2000	1,045			52	52	61	14
15	BLOW OFF VALVE	2000	1,001			50	50	58	15
16	MIXING VALVE	2000	3,369			168	168	196	16
17	TRANSMITTER	2000	924			46	46	54	17
18	MOTOR	2000	609			30	30	43	18
19	CUBICLES	2000	10,155			508	508	677	19
20	HATCH SILL	2000	1,970			99	99	124	20
21	EXPANSION TANK	2001	572			29	29	29	21
22	PIPE INSULATION	2001	956			48	48	48	22
23	PILOT ASSEMBLY	2001	518			26	26	26	23
24	MOTOR	2001	1,135			57	57	57	24
25	DRYWALL	2001	638			64	64	64	25
26	MOTOR	2001	1,386			63	63	63	26
27	TRANSMITTER	2001	924			42	42	42	27
28	WIRING	2001	1,274			59	59	59	28
29	GENERATOR	2001	589			27	27	27	29
30	PAINT	2001	924			35	35	35	30
31	CUBICLE CURTAINS	2001	17,136			786	786	786	31
32	ELEVATOR	2001	1,522			57	57	57	32
33	FLAME CONTROL CENTER	2001	1,402			105	105	105	33
34	TOTAL (lines 1 thru 33)		$ 842,707	$ 115,198		$ 41,138	$ (74,060)	$ 181,493	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 842,707	$ 115,198		$ 41,138	$ (74,060)	$ 181,493	1
2	AIR CONDITIONING	2001	1,294			43	43	43	2
3	CUBICLE CURTAINS	2001	693			46	46	46	3
4	FIRE ALARM	2001	800			53	53	53	4
5	TRANSMITTER	2001	940			63	63	63	5
6	FLOW SWITCH	2001	765			51	51	51	6
7	COMPRESSOR	2001	1,218			36	36	36	7
8	SEWER LINES	2001	3,692			108	108	108	8
9	WINDOW COVERINGS	2001	2,328			58	58	58	9
10	STEEL SHUTES,DOOR	2001	1,332			67	67	67	10
11	DOMESTIC WATER PIPIN	2001	548			11	11	11	11
12	EXHAUST SYSTEM	2001	543			23	23	23	12
13	FENDERS	2001	5,285			220	220	220	13
14	WIRING	2001	1,140			57	57	57	14
15	TRANSMITTER	2001	924			46	46	46	15
16	STEEL DOOR	2001	1,199			25	25	25	16
17	WIRING	2001	4,785			239	239	239	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	1
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	1
2									2
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 870,193	$ 115,198		$ 42,284	$ (72,914)	$ 182,639	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	CCI Alloc		1996		47,856	1,227	35	1,367	140	6,951	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION FROM CARE CENTERS			2001	136	18	20	4	(14)	4	9
10	ALLOCATION FROM CARE CENTERS			2000	58	1	20	3	2	5	10
11	ALLOCATION FROM CARE CENTERS			1999	857	22	20	43	21	124	11
12	ALLOCATION FROM CARE CENTERS			1998	354	9	20	18	(9)	65	12
13	ALLOCATION FROM CARE CENTERS			1997	5,020	89	20	277	188	1,618	13
14	ALLOCATION FROM CARE CENTERS			1996	5,517	73	20	291	218	1,143	14
15	ALLOCATION FROM CARE CENTERS			1997	582	135	20	25	(110)	82	15
16	ALLOCATION FROM CARE CENTERS			1994		16	20		(16)		16
17	ALLOCATION FROM CARE CENTERS			1993		5	20		(5)		17
18											18
19											19
20											20
21											21
22											22
23											23
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 60,380	$ 1,595		$ 2,028	$ 415	$ 9,992	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 517,215	$ 4,829	$ 52,598	$ 47,769		$ 201,601	71
72	Current Year Purchases	7,945	411	562	151		562	72
73	Fully Depreciated Assets	6,250					6,250	73
74								74
75	TOTALS	$ 531,410	$ 5,240	$ 53,160	$ 47,920		$ 208,413	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		CCI ALLOC		$ 23,141	$ 3,541	$ 3,548	$ 7	10	$ 11,417	76
77										77
78										78
79										79
80	TOTALS			$ 23,141	$ 3,541	$ 3,548	$ 7		$ 11,417	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,427,448	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,979	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 98,992	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,987)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 402,469	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sam and David Gorenstein

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building: Edgewater LLC		188		$ 1,015,577			3
4	Additions							4
5	less rental income				(7,219)			5
6	Care Center Allocation				5,277			6
7	TOTAL		188		$ 1,013,635 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: X YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,636 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 330	$	$ 330
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 330	$	$ 330
10	SUM OF line 9, col. 1 and 2 (e)	$ 330			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 4,184	$		$ 4,184	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,823			2,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			9,654			9,654	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				44,132		44,132	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						42,371		42,371	13
14	TOTAL			$		$ 16,661	$ 86,503		$ 103,164	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,823	$ 94,836	1
2	Cash-Patient Deposits	68,878	68,878	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	575,769	660,972	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	160,679	160,679	6
7	Other Prepaid Expenses	14,254	14,254	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	281,655	326,065	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,196,058	$ 1,325,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	736,876	736,876	15
16	Equipment, at Historical Cost	576,325	576,325	16
17	Accumulated Depreciation (book methods)	(472,728)	(472,728)	17
18	Deferred Charges	23,025	23,025	18
19	Organization & Pre-Operating Costs		73,196	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	451,675	451,675	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,315,173	$ 1,388,369	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,511,231	$ 2,714,053	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 394,182	$ 394,182	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	70,468	70,468	28
29	Short-Term Notes Payable	2,721,284	2,721,284	29
30	Accrued Salaries Payable	214,031	214,031	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,264	22,264	31
32	Accrued Real Estate Taxes(Sch.IX-B)	272,655	272,655	32
33	Accrued Interest Payable	127,254	127,254	33
34	Deferred Compensation	3,390	3,390	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	810,415	1,391,200	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,635,943	$ 5,216,728	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,635,943	$ 5,216,728	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,124,712)	$ (2,502,675)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,511,231	$ 2,714,053	48

*(See instructions.)

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (894,941)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (894,941)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,229,771)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,229,771)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,124,712)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,573,839	1
2	Discounts and Allowances for all Levels	(161,807)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,412,032	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	73,955	6
7	Oxygen	(92)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 73,863	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,219	16
17	Sale of Drugs	41,460	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,492	19
20	Radiology and X-Ray	1,134	20
21	Other Medical Services	135,386	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 190,691	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	767	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 767	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,677,382	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,227,718	31
32	Health Care	2,262,271	32
33	General Administration	1,688,305	33
	B. Capital Expense		
34	Ownership	2,522,765	34
	C. Ancillary Expense		
35	Special Cost Centers	103,164	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,907,153	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,229,771)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,229,771)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,095	2,187	$ 64,720	$ 29.59	1
2	Assistant Director of Nursing	1,321	1,378	26,860	19.49	2
3	Registered Nurses	13,524	14,861	312,473	21.03	3
4	Licensed Practical Nurses	26,067	29,548	556,212	18.82	4
5	Nurse Aides & Orderlies	81,346	90,690	776,073	8.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,303	5,878	89,967	15.31	8
9	Activity Director	1,968	2,232	36,883	16.52	9
10	Activity Assistants	11,548	12,306	87,920	7.14	10
11	Social Service Workers	9,998	10,731	125,138	11.66	11
12	Dietician					12
13	Food Service Supervisor	2,564	2,624	35,119	13.38	13
14	Head Cook	5,176	5,662	47,213	8.34	14
15	Cook Helpers/Assistants	15,359	16,712	118,493	7.09	15
16	Dishwashers					16
17	Maintenance Workers	3,600	4,063	51,532	12.68	17
18	Housekeepers	21,985	23,734	156,406	6.59	18
19	Laundry	8,253	8,965	63,867	7.12	19
20	Administrator					20
21	Assistant Administrator	1,224	1,240	11,989	9.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,524	9,191	104,001	11.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,917	2,229	29,478	13.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,772	244,231	$ 2,694,344 *	$ 11.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	352	$ 14,083	01-03	35
36	Medical Director	MONTHLY	6,000	09-03	36
37	Medical Records Consultant	MONTHLY	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,645	10-03	39
40	Physical Therapy Consultant	20	983	10a-03	40
41	Occupational Therapy Consultant	35	1,773	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,245	10a-03	43
44	Activity Consultant	46	2,112	11-03	44
45	Social Service Consultant	MONTHLY	1,764	12-03	45
46	Other(specify)				46
47	CCI Costs - See Attached		11,136	Various	47
48					48
49	TOTAL (lines 35 - 48)	478	$ 46,773		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	265	$ 10,589	10-03	50
51	Licensed Practical Nurses	529	15,882	10-03	51
52	Nurse Aides	1,323	26,470	10-03	52
53	TOTAL (lines 50 - 52)	2,117	$ 52,941		53

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID VARDI	ASST. ADMINISTRATOR	0	$ 11,989
ADMINISTRATOR'S SALARY			
DIRECTLY ALLOCATED FROM			
HOME OFFICE			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 11,989

B. Administrative - Other

Description	Amount
CCI ADMINISTRATIVE PAYROLL (ADJUSTED ON P.6B)	$ 89,013
CHRIS WAYER	175
ERIC ROTHNER - MGT FEE	12,000
NATHAN LANGSNER - MGT FEE	8,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 109,188
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 21,048
Care Centers	Accounting	9,428
See Attached	Data Processing	10,610
See Attached	Legal	82,852
Personel Planners	Unemployment Cons	1,507
Care Centers	Bookkeeping	22,372
Care Centers	Proffessional fees	1,000
See Attached	Other Professional	2,321
Judy Ginsburg	Computer Consultant	1,000
Care Centers	Home Office Expense	92,120
Care Centers	Ancillary Admin Fees	13,160
Accrued Exp. (adjusted p. 5)	Home Office Expense	30,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 287,418

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,019
Unemployment Compensation Insurance	37,290
FICA Taxes	206,117
Employee Health Insurance	136,217
Employee Meals	27,850
Illinois Municipal Retirement Fund (IMRF)*	
Chicago HD Tx	9,835
Pension Exp	27,684
Misc Emp Wellfare	9,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 537,477

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,343
Health Care Worker Background Check	
(Indicate # of checks performed 191)	2,288
Licenses	2,645
Subscriptions	6,037
Advertising	9,922
Yellow Page Advertising	286
Alloc CCI	1,924
Alloc CCI -Health Sys.	8
Less: Public Relations Expense	
Non-allowable advertising	(9,922)
Yellow page advertising	(286)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,245

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,917
ALLOC CCI	1,400
ALLOC CCI - HEALTH SYS.	1
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,318

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL $7610**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,391** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **102,930**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **27,850** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees